MDR Tracking Number: M5-05-1305-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-6-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, hot-cold pack therapy, electrical stimulation-unattended, therapeutic exercise, manual therapy, electrical stimulation and Ankle and Foot Orthosis multiligus ankle support for 12-12-03 through 2-11-04 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service are denied and the Medical Review Division declines to issue an Order in this dispute.

This Finding and Decision is hereby issued this 3rd day of April 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

April 7, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-1305-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health

care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 41 year-old male injured his left ankle and foot on ___ when a large pipe fell on him. X-ray showed a fracture of the distal fibula and a cast was place. He has been treated with therapy and medications.

Requested Services

Office visits, hot/cold pack therapy, electrical stimulation – unattend, therapeutic exercise, manual therapy, electrical stimulation, Ankle and Foot Orthosis (AFO) multiligus ankle support for dates of service 12/12/03 through 02/11/04

Decision

It is determined that there is no medical necessity for the office visits, hot/cold pack therapy, electrical stimulation – unattended, therapeutic exercise, manual therapy, electrical stimulation, and Ankle and Foot Orthosis (AFO) multiligus ankle support for dates of service 12/12/03 through 02/11/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. The Guidelines of *Chiropractic Quality Assurance and Practice Parameters*[1] Chapter 8 under "Failure to meet Treatment/Care objective" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." In this case, the patient received all disputed treatments after the 4-week time period and without significant documented improvement. Therefore, the office visits, hot/cold pack therapy, electrical stimulation – unattended, therapeutic exercise, manual therapy, electrical stimulation, and Ankle and Foot Orthosis (AFO) multiligus ankle support for dates of service 12/12/03 through 02/11/04 were not medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment
GBS:
Attachment

[1] Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractor Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1305-01

Information Submitted by Requestor:

- Carriers Position
- Office Notes
- Therapy Notes
- Diagnostic Tests
- Independent Record Review
- Claims

Information Submitted by Respondent:

- Office Notes
- Independent Medical Reivew
- Diagnostic Tests